

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Matthew Xavier, a prisoner at HMP Highpoint, on 16 December 2022.

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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Summary

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.
2. If my office is to best assist HM Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.
3. Mr Matthew Xavier died in hospital on 16 December 2022, of lung cancer while a prisoner at HMP Highpoint. He was 65 years old. We offer our condolences to his family and friends.
4. The clinical reviewer concluded that the clinical care Mr Xavier received at HMP Highpoint was equivalent to what he could have expected to receive in the community. The clinical reviewer made no recommendations.
5. The decision to keep Mr Xavier restrained until the day before he died was not justified given his deterioration in health and mobility.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that, in all cases:
 - healthcare staff complete the medical information section of the escort risk assessment, accurately reflecting how the prisoner's current health and medical condition affects their risk of escape; and
 - authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.
- The Operational Security Group Director for HMPPS should monitor, over the next three months, how many prisoners at HMP Highpoint are escorted to hospital without restraints (for inpatient admissions and outpatient appointments) and report back to the Ombudsman.

The Investigation Process

6. On 16 December 2022, HMPPS informed us of Mr Xavier's death.
7. NHS England commissioned an independent clinical reviewer to review Mr Xavier's clinical care at Highpoint.
8. The PPO investigator investigated the non-clinical issues relating to Mr Xavier's care.
9. The PPO family liaison officer wrote to Mr Xavier's wife to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
11. Mr Xavier's family received a copy of the initial report. They pointed out some factual inaccuracies and/or omissions. This report has been amended accordingly. Mr Xavier's family also raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Previous deaths at HMP Highpoint

12. Mr Xavier was the sixth prisoner to die at Highpoint since December 2019. Of the previous deaths, three were from natural causes, and two were self-inflicted.
13. In a previous investigation into the death of a prisoner at Highpoint in 2021, we identified the inappropriate use of restraints and made a recommendation. Highpoint accepted our recommendation and said that they would ensure all escorts and bed watches had appropriate and adequate medical input and disclosure within the medical section of the risk assessment, and staff were reminded of these requirements in February 2022.

Key Events

14. On 23 March 2018, Mr Matthew Xavier was sentenced to 12 years in prison for grievous bodily harm. He was sent to HMP Norwich.
15. On 9 May 2022, Mr Xavier was transferred to HMP Highpoint.
16. On 21 November, a GP at the prison saw Mr Xavier after he reported a lump in the left side of his neck. The GP examined him and diagnosed 'likely malignancy' and referred him for further tests under the two-week wait referral process. (The two-week appointment system was introduced so that any patient with symptoms that might indicate cancer, or a serious condition such as cancer, could be seen by a specialist as quickly as possible).
17. On 1 December, an officer attended Mr Xavier's cell because two prisoners pressed Mr Xavier's emergency cell bell. They told the officer that Mr Xavier was unresponsive, they had shaken him to rouse him, and he then took a sharp intake of breath. The officer radioed a code blue (indicating a prisoner is unconscious or is having breathing difficulties) and healthcare staff attended. Mr Xavier said that he was having difficulty breathing and complained of a sharp pain to his left shoulder, radiating through to his chest. Mr Xavier was taken to hospital with a possible diagnosis of sepsis (the body's extreme response to an infection, which can be a life-threatening medical emergency). Mr Xavier was escorted to hospital by two officers and was restrained using single handcuffs and an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).
18. On 2 December, the hospital informed healthcare staff at the prison that Mr Xavier was being cared for in the 'Rapid Assessment Unit' and had a possible new diagnosis of pneumonia. A few days later, the hospital informed healthcare staff at the prison that Mr Xavier had been diagnosed with stage four lung cancer. Mr Xavier remained restrained.
19. On 8 December, Mr Xavier's condition began to deteriorate, and he was much more breathless. The Head of Healthcare at Highpoint emailed the Head of Safer Custody and suggested that they remove Mr Xavier's handcuffs due to his decline in health and consider making an application for compassionate release. However, it was agreed that handcuffs would remain, as Mr Xavier was still mobile and there was no confirmed treatment plan.
20. That day, due to a deterioration in Mr Xavier's condition, the hospital put in place a Do not Attempt Cardiopulmonary Resuscitation order on Mr Xavier's behalf, which meant that in the event his heart or breathing stopped, he would not be resuscitated.
21. On 9 December, prison staff started the compassionate release process. However, this had not been completed before Mr Xavier died.
22. That day, an officer was on bedwatch duty at the hospital and called a prison manager at Highpoint to ask if he could remove Mr Xavier's handcuffs on compassionate grounds. The prison manager said that the handcuffs needed to remain as they were until a further risk assessment was completed.

23. On 13 December, the Head of Healthcare confirmed that she had had a discussion with a prison manager about removing Mr Xavier's handcuffs. They decided that Mr Xavier's restraints could be removed due to him becoming less independent and his movements were restricted due to needing more oxygen. The necessary processes began for this to happen.
24. The next day, a doctor at the hospital told prison staff that Mr Xavier's health had deteriorated, he had very limited mobility and was reliant on a permanent supply of oxygen. On the 15 December, the Head of Security at Highpoint completed a new risk assessment, and the restraints were then removed, following the agreement already made on 13 December and information provided by the hospital.
25. On the morning of 16 December, doctors at the hospital said Mr Xavier had hours to live, and he was placed on end-of-life care. At 1.15pm, it was confirmed that Mr Xavier had died.

Cause of death

26. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Xavier's cause of death as metastatic small cell lung cancer (an aggressive form of lung cancer that grows and spreads rapidly).
27. At the inquest held on 23 April 2024, the coroner concluded that Mr Xavier died from metastatic small cell lung cancer.

Non-Clinical Findings

Restraints, security and escorts

28. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.
29. The nurse who completed the risk assessment paperwork for the escort on 1 December 2022, wrote 'medical in confidence' in the medical section of the paperwork and provided no information about Mr Xavier's current medical condition. This meant that the authorising manager was not fully aware of Mr Xavier's state of health and how this affected his risk of escape. As a result, the level of restraints authorised for Mr Xavier was not proportionate to the risk he posed.
30. Prison staff asked prison managers to remove Mr Xavier's restraints on compassionate grounds on 9 December as his health was rapidly declining. The risk assessment should have been reviewed when his circumstances changed on 2, 9 and 13 December. In fact, the risk assessment was not reviewed until 15 December, the day before Mr Xavier died, after a doctor at the hospital told prison staff that Mr Xavier's mobility was limited, and he needed continuous oxygen. It was at this point that prison managers approved the removal of restraints.
31. We make the following recommendations:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that, in all cases:

- **healthcare staff complete the medical information section of the escort risk assessment, accurately reflecting how the prisoner's current health and medical condition affects their risk of escape; and**
- **authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.**

The Operational Security Group Director for HMPPS should monitor, over the next three months, how many prisoners at HMP Highpoint are escorted to hospital without restraints (for inpatient admissions and outpatient appointments) and report back to the Ombudsman.

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Prisons and Probation Ombudsman

August 2024

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